



Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities

Submission to the House of Representatives Standing Committee on Indigenous Affairs

From Professor Kate Conigrave, Dr Kylie Lee and Mr Peter Jack
University of Sydney, Discipline of Addiction Medicine
NSW 2006

April 2014

Executive Summary

Aboriginal and Torres Strait Islander (Indigenous) Australians are at increased risk of alcohol-related harms because of a complex mix of inter-generational disadvantage, disempowerment, trauma and loss. It is important that government responses to address this problem empower rather than disempower communities, families and individuals. Otherwise these may potentially unwittingly exacerbate rather than reduce risky alcohol use.

Based on the evidence presented in this submission, we make the following recommendations:

1. The government has a responsibility to apply evidence-based solutions to reduce the unacceptable burden of harm from alcohol, not just to Indigenous Australians, but also to all Australians. This includes controlling the supply of alcohol through taxation based on the volume of pure alcohol, through pricing measures, and through limiting the density and opening hours of licensed premises. The economic value of alcohol sales must come second to human health and quality of life.
2. Other local alcohol supply reduction measures, developed in partnership with local Indigenous communities, may also be beneficial.
3. Many Indigenous communities have worked to reduce the impact of alcohol on their communities. These efforts need further support, and in particular support for:
 - Indigenous women who may want to speak up about the harms of alcohol.
 - Challenging inappropriate liquor licenses, or efforts to impose conditions on licenses.
 - Development of better opportunities for young people.
4. The government needs to work with Indigenous communities to enhance the resilience of young people, providing them with opportunities to develop a sense of connectedness, self-respect, identity and control over their environment. Such opportunities can include through improved school environments, supporting opportunities for involvement with culture, and meaningful training and employment activities, as well as increased recreational options.
5. Education on the harms of alcohol alone is far less likely to be effective than education which is combined with measures to increase youth resilience and opportunity.
6. Indigenous Australians have a right to modern evidence-based treatments for alcohol problems (including skilled counselling, relapse prevention medications, and management of comorbid mental health conditions).
7. Alcohol treatment services are more likely to be accessible if delivered in a culturally secure manner.
 - Indigenous health professionals have a key role in ensuring accessible and appropriate treatment. These workers need support for further opportunities for career development, job security and ongoing skills development.

- Non-Indigenous health professionals need to work in partnership with Indigenous health professionals, community controlled agencies and community to ensure that mainstream treatment services deliver care in an accessible and culturally secure manner.
8. Residential withdrawal management (detoxification) and rehabilitation services need to be funded and staffed in a way that enable individuals with complex physical and mental health conditions to be cared for in such services.
 9. There needs to be improved availability to quality mental health care and integration of this with alcohol treatment services.
 10. Indigenous community controlled health services need support to enhance their ability to provide evidence-based screening and care for alcohol misuse.
 11. FAS and FASD can cause lifelong disability and should be included for consideration as a recognised disability. This is important so that sufferers and their carers can have greater access to greater support and early intervention services; in particular sufferers should be directed to therapy rather than punishment.
 12. It is ethically highly dubious to have mandatory treatment in settings without ready availability of voluntary treatment.
 13. Any mandated treatment needs to be delivered in a manner that is culturally appropriate and clinically of high quality.
 14. Efforts need to be made to divert more Indigenous Australians with alcohol problems out of prisons and into the treatment system.
 15. Quality data collection is needed on alcohol sales, alcohol consumption patterns and alcohol-related harms. These should be made available to researchers, policy makers and community to better monitor and inform efforts to reduce harms from alcohol.
 16. Further investment is needed in quality research into developing or evaluating treatment and prevention efforts tailored to Indigenous Australians.

Patterns of supply of, and demand for alcohol in different Aboriginal and Torres Strait Islander communities, age groups and genders

Limitations to available data: Reliable population estimates of alcohol use and related harms are key to the design and monitoring of initiatives to prevent and treat harmful use of alcohol. However, there are severe shortcomings in population data collected on alcohol consumption among Aboriginal and Torres Strait Islander (Indigenous) Australians (Chikritzhs and Brady 2006; Chikritzhs and Brady 2007; Chikritzhs, Pascal et al. 2007; Chikritzhs and Liang 2012). For example, estimates from the largest national Indigenous social survey in Australia have been reported to underestimate alcohol use by over 200 per cent for males and 700 per cent for females (Chikritzhs and Liang 2012). These deficits are likely to have contributed to chronic under-funding of alcohol prevention and treatment services. It is important that improved methods be developed for data collection, in collaboration with Indigenous community and community controlled health services. These must address limitations to current questionnaire design, survey administration and sampling.

What available data tells us: Available data suggest that there are less current drinkers among Indigenous Australians than the remainder of the Australian population, but that those who do drink, are more likely to consume in a way that puts them at risk of long-term health problems (e.g. cancers, high blood pressure, diabetes and alcohol-related brain damage). In addition, episodic heavy drinking is a common pattern (Commonwealth Department of Human Services and Health 1996). This style of drinking places drinkers at greatly increased risk of trauma of all kinds, including accidental and deliberate injury. As trauma is the leading cause of Indigenous hospitalisation and the third highest cause of disability and of premature death for Indigenous Australians (Australian Institute of Health and Welfare 2011), reducing risky alcohol consumption will be a key step in reducing the health gap between Indigenous Australians and their non-Indigenous counterparts.

No population level data is available on the prevalence of alcohol dependence among Indigenous Australians. This makes it challenging to plan for treatment service needs and to monitor the adequacy of service availability. However in the prison systems there is a high prevalence of alcohol dependence has been reported. One study found that almost half (45%) of Indigenous inmates were likely to be dependent on alcohol (Kinner, Dietze et al. 2012) compared with a general population prevalence of alcohol dependence of just 1.4% (Teesson, Hall et al. 2010).

The social and economic determinants of harmful alcohol use across Aboriginal and Torres Strait Islander communities

Indigenous Australians are more likely than other Australians to face unemployment, social disadvantage and racism (Australian Institute of Health and Welfare 2011). Indigenous

communities themselves have identified limited employment, recreational and cultural opportunities as risk factors for substance misuse (Lee, Conigrave et al. 2008). This is in keeping with international evidence that disadvantage and disempowerment are associated with risky patterns of drinking (Marmot, Stansfeld et al. 1991; Mulia, Ye et al. 2008).

Indigenous Australians are far more likely to experience major stress (Australian Institute of Health and Welfare 2011; Nadew 2012), including through death, physical or emotional trauma, separation, separation because of imprisonment of relatives, and violence. Experience of stress, particularly in childhood, can predispose an individual to alcohol use disorders (Nadew 2012; Niwa, Jaaro-Peled et al. 2013; Spanagel, Noori et al. 2014). Even in animal experiments, stress induces craving for alcohol, and this has been linked to changes to the brain's neurochemistry, including changes to the reward centre (Enoch 2011; Spanagel, Noori et al. 2014). Some of these brain changes are mediated through alterations to gene expression (i.e. epigenetic changes) (Niwa, Jaaro-Peled et al. 2013; Spanagel, Noori et al. 2014). These new understandings are likely to provide clues to medical therapies for alcohol dependence. However addressing the causes of stress and disadvantage will remain key.

In contrast to the role of stress and disempowerment in predisposing to alcohol use disorders, interventions that make young people (in the general population) feel more connected and empowered can make them less likely to develop substance use problems later in their teenage years (Bond, Butler et al. 2007). This is in keeping with reports from Indigenous communities that interventions to prevent or treat substance use that involve a broad range of approaches to engage and empower young people are more likely to prevent substance misuse (Lee, Jagtenberg et al. 2013).

Trends and prevalence of alcohol-related harm, including alcohol-fuelled violence and impacts on newborns e.g. Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorders

Alcohol-related hospitalisations: In keeping with their more frequent experience of physical and mental health conditions, Indigenous Australians are also significantly more likely to be hospitalised as a result of an alcohol-related condition (Wilson, Stearne et al. 2010). The scale of hospitalisation for alcohol-related assault is particularly distressing with Indigenous women 33 more times more likely to be admitted for care as victims of assault than other Australian women (Australian Bureau of Statistics & Australian Institute of Health and Welfare 2008). Indigenous men are six times as likely to be hospitalised for assault as their non Indigenous peers (Australian Bureau of Statistics & Australian Institute of Health and Welfare 2008). In keeping with these figures, Indigenous Australians are seven times more likely to die from an assault as their non-Indigenous peers (Australian Institute of Health and Welfare 2011).

High rates of Indigenous imprisonment related to alcohol: The huge impact of alcohol on violence and crime is reflected by the high rates of Indigenous imprisonment, with more than a quarter (26%) of prisoners being Indigenous, although they only comprise just 2.5% of the total general population (Australian Institute of Health and Welfare 2011). In one prison survey, nearly half (45%) of Indigenous prisoners were found to be alcohol dependent (Kinner, Dietze et al. 2012). This high prevalence of alcohol dependence among prisoners highlights the need for expansion of programs for diversion into treatment rather than the criminal justice system, and greater availability of comprehensive treatment for alcohol dependence among the prison population, combined with quality aftercare (National Indigenous Drug and Alcohol Committee 2009).

Alcohol and cancer: The long-term effects of alcohol on health are also of great concern. Alcohol is a well recognised (group one) carcinogen (Winstanley, Pratt et al. 2011), and cancer is now the second most common cause of death for Indigenous Australians (Australian Institute of Health and Welfare 2011). Reducing alcohol consumption is key to reducing the incidence of premature death.

FASD: Nationally there is poor availability of figures on the prevalence of FASD; however already we have seen that Indigenous Australians have a higher prevalence of FASD than the remainder of the Australian population (Elliott, Payne et al. 2008). Anecdotally certain remote Indigenous communities have a particularly high prevalence of the condition. Of particular concern is that in the majority of remote communities there is a lack of access to treatment services for pregnant women (and other drinkers) who are dependent on alcohol. For these women, education is unlikely to be enough, and access to full range of measures to treat alcohol dependence is needed (Conigrave and Lee 2012). Furthermore, systematic screening and early intervention for risky alcohol misuse in women of childbearing age is important, and well as community- wide education to raise awareness of the risks of alcohol use to the developing fetus. In addition, given that alcohol is a known teratogen, all containers of alcohol and all licensed premises should be required to display clear warnings about the risks of drinking while pregnant.

The implications of Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorders being declared disabilities

Given the severity of harms experienced by individuals with FAS and with more severe FASD, it is highly appropriate that these be considered as disabilities. This would facilitate greater support for carers of children with FAS and FASD, improved detection and early intervention for individuals suffering FASD, and encourage more compassionate handling of offenders with FASD by the justice system. Current approaches in each of these domains are very deficient, with poor detection and lack of formal early intervention programs or support for carers. It is also highly inappropriate that offenders with a developmental cognitive impairment are held in a general prison

setting. Formal recognition of FAS as a disability would also raise awareness of the condition and encourage appropriate warnings on alcohol containers and in licensed premises.

Best practice treatments and support for minimising alcohol misuse and alcohol-related harm

What is international best practice in alcohol dependence treatment? The national alcohol treatment guidelines (Haber, Lintzeris et al. 2009; Haber, Lintzeris et al. 2009) set out elements of modern evidence-based alcohol treatment. These include screening and early intervention, management of alcohol withdrawal, and the range of relapse prevention approaches including skilled counselling, relapse prevention medications and group-based approaches.

Anecdotally these evidence-based treatment approaches are often not available to Indigenous Australians (Conigrave, Ella et al. 2011). In particular there is a lack of residential treatment available, including for both withdrawal management (i.e. detoxification) and rehabilitation. There is also a lack of coordination between withdrawal management and rehabilitation services, so that drinkers are often required to return home after detoxing while they await a bed in a rehabilitation unit. Many individuals relapse to drinking while waiting. Few rehabilitation units have withdrawal management units attached. Some general hospitals are anecdotally reluctant to admit Indigenous Australians (and perhaps others) for withdrawal management, particularly in rural regions.

How can alcohol dependence treatments best be tailored to meet the needs of Indigenous Australians? A number of evaluations have reported feedback from clients of alcohol and drug treatment services and community members on optimal alcohol or drug treatment service delivery, and what they perceive to be barriers or enablers to receiving care. Even in an urban setting, transport to treatment services is identified as a barrier to treatment access (Conigrave, Freeman et al. 2012). In a rural or remote setting, individuals may need to travel hundreds of kilometres to access care. There are risks involved in transporting a recent drinker over large distances to a withdrawal management ('detox') unit, given the risks of seizures, which typically occur early in withdrawal (Haber, Lintzeris et al. 2009; Latt, Conigrave et al. 2009). Lack of access to childcare is another barrier to help seeking (Conigrave, Freeman et al. 2012), with few services providing accommodation for women (or men) with children in their care. Furthermore, most treatment services are aimed at the individual drinker, whereas many Indigenous Australians drink with family members or friends, and so (where there is interest), making treatment available to whole families or groups of drinkers may be more appropriate.

Holistic care for mental health and substance use co-morbidity

Only limited published research is available on optimal approaches to help or treat Indigenous Australians with co-occurring alcohol and other drug, and mental disorders (Lee, Harrison et al.

2014). Despite its importance, treatment of substance use and mental health co-morbidity is typically poorly coordinated (Canaway and Merkes 2010), with separate funding allocated for mental health and alcohol and other drug services, resulting in considerable barriers for clients navigating health systems (Holt, Treloar et al. 2007; Canaway and Merkes 2010). It is important that treatment services are funded and planned in such a way that they have the capacity to offer comprehensive care to those with mental and physical co-morbidity (New South Wales Health 2008; Nagel, Kavanagh et al. 2011). At present, anomalies in resource allocation, workforce size, skills and priorities between these sectors can make integration challenging on a practical level (Canaway and Merkes 2010). Well-defined links to specialist services are also required (Aboriginal Medical Services Alliance of the Northern Territory 2008) (e.g. psychology, psychiatry, addiction medicine). However, currently there are severe shortages in specialist care, particularly in non-urban areas.

A holistic approach is needed to effectively address the complex range of issues experienced by clients and to better support family members (Lee, Harrison et al. 2014). This should include approaches to also address underlying issues of repeated trauma, stress and grief, that are offered in a respectful cultural framework (Berry and Crowe 2009). A range of other improvements is needed, including more local inpatient and outpatient treatment options, and greater accessibility of these services to clients and families (Lee, Harrison et al. 2014). There are clearly community strengths and commitment (among both families and staff) that can be built on to improve service delivery for this vulnerable client group (Lee, Harrison et al. 2014).

The important role of Indigenous health professionals in ensuring accessible and appropriate care
Indigenous alcohol and other drug workers are often the first point of contact for Indigenous people seeking help for alcohol and other drug (AOD) related issues (National Rural Health Alliance 2006), and their relationship with local community can be a significant factor influencing whether individuals seek help from that service (Mitchell and Hussey 2006). Indigenous alcohol and other drug workers also play a key role in tailoring AOD services to Indigenous Australians (Tongs, Chatfield et al. 2005; Ministerial Council on Drug Strategy 2006; Williams, Nasir et al. 2006; Teasdale, Conigrave et al. 2008; Taylor, Bessarab et al. 2013) and making services more culturally secure (Ministerial Council on Drug Strategy 2006).

However the role of the Indigenous alcohol and other drug workers is typically diverse, complex (National Rural Health Alliance 2006) and poorly defined (Ella 2013). Depending on the individual staff member and the service needs, this role can change from community support to advocate (for clients, families, communities or organisations), to health promotion, cultural advisor, counsellor or clinician (Rose and Pulver 2004; National Rural Health Alliance 2006).

The demands placed on Aboriginal alcohol and other drug workers are considerable (Roche, Tovell et al. 2010; Roche, Duraisingam et al. 2013). Because of community and cultural obligations, workers often provide help outside business hours. Senior workers often contribute to policy on local, state or national committees (NSW Department Of Health 2009). Given their range of responsibilities and educational backgrounds (Ella, Lee et al. 2012), it can be challenging for workers to be adequately prepared for their duties. Workplace training and supervision (Kavanagh, Spence et al. 2002; Ask 2005; Health Workforce Australia 2011) are key to optimising the contribution of health professionals, to reducing undue strain and providing appropriate professional development opportunities (Brunero and Stein-Parbury 2008).

Further research needs to investigate inequities in salary and award conditions between non-government and government employees, and consider how position titles and job descriptions might best be determined. It could also investigate the types and suitability of clinical and cultural supervision currently offered; and supervisors' understanding of relevant cultural issues. This would be fundamental in determining if the clinical supervision process is likely to be beneficial (Ask 2005; Roche, Tovell et al. 2010). Greater role clarity and improved opportunities for support and clinical and cultural supervision will build a stronger safety net to help workers continue to address AOD issues, and to further build expertise and create career development pathways.

Indigenous specific approaches

There has been limited funding made available for systematic and quality analysis of the effectiveness of Indigenous specific alcohol treatment approaches. Anecdotally, successful treatment and prevention programs initiated by Aboriginal communities have often instinctively included elements of cultural or spiritual enhancement (Lee, Jagtenberg et al. 2013). This fits well with the international evidence on the importance of connectedness in building resilience in preventing alcohol problems. Increasingly, Indigenous specific approaches are being combined with best 'western' medicine approaches to manage alcohol problems. So that women's' groups, for example, are being included in a mainstream treatment service (Lee, Dawson et al. 2013); or anecdotally alcohol relapse prevention medications are increasingly being used within Indigenous community controlled health services.

Indigenous community controlled health services are particularly well placed to engage and work with Indigenous Australians at risk with drinking problems. In this context systematic screening with standardized questions, can better detect and monitor individuals who are at risk because of their drinking. However, as with mainstream primary health services (Reid, Webb et al. 1986; Anderson, Kaner et al. 2003), there can be a range of barriers to providing evidence-based care for alcohol problems. Further support and appropriate funding is needed to enhance the

implementation of quality diagnosis and care of alcohol use disorders in Aboriginal community controlled primary care settings.

Several mainstream specialist alcohol and drug treatment services have reported on the benefits of working in partnership with Indigenous community controlled organizations or community representatives to improve the accessibility and appropriateness of service delivery (Teasdale, Conigrave et al. 2008; Allan and Campbell 2011).

Measures to treat alcohol problems among young Indigenous Australians

Even in general populations, the evidence for the treatment of alcohol use disorders in young Indigenous Australians is sparse. A range of counseling approaches has been shown to be effective for alcohol (Tripodi, Bender et al. 2010). Promising approaches have combined separation from the supply of a substance combined with measures to increase resilience and sense of connection and identity, and control (Preuss and Napanangka Brown 2006; Lee, Jagtenberg et al. 2013).

For young Indigenous Australians with alcohol dependence, there is reportedly very limited access to treatment services (Gray, Stearne et al. 2010). For young Australians more generally residential treatment program access can also be a problem. It is clearly important to ensure appropriate access of Indigenous young people to the full range of evidence-based treatments for alcohol dependence, adapted to be culturally appropriate and accessible (Ministerial Council on Drug Strategy 2006) even while efforts continue to find ever better treatment and prevention approaches (Lee, Jagtenberg et al. 2013).

Mandatory treatment and imprisonment of those who drink when banned

There are significant ethical concerns with implementing mandatory treatment when there is lack of availability of readily accessible and voluntary treatment, and when there is a lack of evidence-based alcohol misuse supply reduction measures. In the uncommon cases where there is a strong case for the benefit of mandatory treatment, it is important that this treatment comprise quality and state-of-the-art care.

Laws which potentially punish a dependent drinker with imprisonment for consuming alcohol would seem ethically inappropriate when a defining feature of alcohol dependence is loss of control over drinking (World Health Organization 1992). Such laws currently exist in the Northern Territory, in relation to Alcohol Protection Orders (Northern Territory Police). Similarly, in other parts of Australia, alcohol abstinence can be required as a condition of parole. In such cases, a lack of alcohol treatment services or inability of a drinker to control their consumption can lead to imprisonment.

Best practice strategies to minimise alcohol misuse and alcohol-related harm (prevention)

Supply reduction interventions

Alcohol cost (and volumetric tax): One proven measure to reduce risky use of alcohol in any population is to reduce the supply of alcohol. This includes measures to increase the price of alcohol, and in particular, by imposing a tax based on the volume of pure alcohol (volumetric tax) and a minimum price for a serve of alcohol (Steven J. Skov for the Royal Australasian College of Physicians Alcohol Advisory Group 2009). Expert economic advice has affirmed the judgement that a volumetric tax on alcohol would be likely to reduce alcohol related harms (Henry 2011).

Supply reduction efforts developed with communities: Efforts at supply limitation should be made in consultation with community. There are many examples of successful community efforts to reduce supply of alcohol, with resulting striking reductions of harm (Gray, Siggers et al. 2000; Conigrave, Proude et al. 2007; Elliott, Latimer et al. 2012). In contrast, if supply control is externally imposed and discriminatory it can potentially lead to increased sense of stress and disempowerment. Given the association between disempowerment and alcohol misuse (described above) discrimination can in fact place individuals at greater risk of alcohol misuse.

Supporting communities to challenge inappropriate supply of alcohol: It can be very difficult for a community to challenge inappropriate supply of alcohol or to seek supply reduction. The legal and licensing environment can be complex, even for those with advanced academic literacy, let alone for disadvantaged communities. Supporting communities to challenge inappropriate supply of alcohol is important. In NSW, a pilot project, the Alcohol Community Action Project (ACAP 2014) is supporting communities to address alcohol concerns. However it is not yet clear how accessible this pilot service will be to Indigenous Australians, and its funding is not secure.

In particular it can be challenging for women affected by alcohol-related violence to safely have a say in supply control decisions (Conigrave, Proude et al. 2007; Lee and Conigrave 2011), and special arrangements may need to be made to hear their voice adequately.

Demand reduction interventions among young Indigenous Australians

Many interventions that have aimed to reduce the demand for alcohol (or other drugs) among young Indigenous Australians have focused on providing drug education (Sheehan, Schonfield et al. 1995; Johnston, Beecham et al. 1998); sport and recreation initiatives (Cairnduff 2001); or cultural activities (Preuss and Brown 2006). However, these efforts have not been comprehensively evaluated. Even for the general population, there is variable evidence on effectiveness of measures to prevent alcohol use disorders among young people (Lee, Jagtenberg et al. 2013). Many preventive programs designed to reduce the demand for alcohol (Foxcroft and

Tsertsavgdze 2011) show variable or weak effectiveness, with the exception of internet-based curricula in secondary schools that are reported to decrease alcohol (and cannabis) use (Newton, Teeson et al. 2010). Other promising interventions do not focus on the delivery of facts about substance use, but are broader and include family-based (Foxcroft, Ireland et al. 2010) or social influence and social competence interventions (Thomas and Perera 2009). Building young people's connectedness in the school environment has been shown to decrease the likelihood of engaging in risky behavior such as substance use (Bond, Butler et al. 2007). Controlling the availability of alcohol and limiting alcohol-related advertising has also been found to be useful, although the quality of studies in this area varies (Paschall, Grube et al. 2009).

The social and cultural needs of young Indigenous Australians may be different to non-Indigenous youth, however there is even less research in this area. A recent review of available literature (Lee, Jagtenberg et al. 2013) suggests that programs should be multi-pronged and offer young people alternatives to alcohol and other drug use. In particular, prevention should be broader rather than facts-based school drug education and it should be longer-term (as opposed to one-off). Furthermore, given the lower rates of school attendance in some Indigenous communities, programs should consider young people both in and out of the school system (Lee, Conigrave et al. 2008). Where supply control measures are combined (e.g. with cultural (Ministerial Council on Drug Strategy 2006) and recreational (Cairnduff 2001) activities, or increased educational and training opportunities) these are likely to be beneficial. The local Indigenous community should be involved in program design, delivery and evaluation (Ministerial Council on Drug Strategy 2006). These common elements are worthy of further assessment, and may be able to act as a guide to service planning (Lee, Jagtenberg et al. 2013).

Best practice identification to include international and domestic comparisons

What is best practice? Screening, prevention, treatment, harm reduction

There is an extensive international literature on best practice detection and management of alcohol problems in international settings, and journals such as *Alcohol and Alcoholism*, *Drug and Alcohol Review* and *Alcoholism, Clinical and Experimental Research* continue to publish new evidence in the field. For example, literature available up to 2009 on the treatment of alcohol use disorders was reviewed for creation of the national alcohol treatment guidelines (Haber, Lintzeris et al. 2009).

A small but growing number of studies have examined what is best practice in Indigenous specific approaches to alcohol misuse prevention, treatment and harm reduction (e.g. Lee, Conigrave et al. 2008; Lee and Conigrave 2010; Conigrave, Freeman et al. 2012; Conigrave and Lee 2012; Lee, Dawson et al. 2013; Lee, Jagtenberg et al. 2013; Lee, Harrison et al. 2014; d'Abbs, Togni et al. 2013; Gray, Wilson et al. 2014).

Recent research has shown the willingness of Indigenous communities, and Indigenous community controlled organisations and academic organisations to work in partnership to perform quality research (Gray, Wilson et al. 2014). However in the past funding for such evaluations has been inadequate, not available at the start of initiatives, or the research or evaluation has had to be done in an unrealistic time frame. Hence the literature has been slow to develop. Further funding is needed to perform systematic and quality research.

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